Postscript

Jack E Henningfield

This conference took place the year before 40 United States Attorneys General reached a widely publicised but tentative settlement with three major tobacco firms: Philip Morris, RJ Reynolds, and British American Tobacco. The process of negotiating and finalising this settlement proposal gives us cause for both optimism and concern. In Washington, DC, we discussed the possibility that tobacco-use intervention could become a standard and universal component of responsible healthcare with the release of the Agency for Health Care Policy and Research (AHCPR) smoking cessation guideline. What we witness with this broadbased proposal is the possibility of a nationwide intervention of unprecedented proportions, involving myriad disincentives to smoke, all with the purported cooperation of the tobacco industry itself. Yet the agenda behind the proposed tobacco settlement seems significantly different from the agenda motivating earlier tobacco control efforts. The primary aim of the proposed settlement is to compensate American states for the health costs of smoking; secondarily, it includes some measures that are expected to reduce the magnitude of public harm caused by tobacco use. Much of the public health community under the general leadership of former Surgeon General C Everett Koop and former Food and Drug Administration Commissioner David A Kessler has advocated a new type of national tobacco policy, which builds on the framework of the proposed settlement but significantly increases the public health focus.

On our current course, as many as 20 million cigarette smokers in the United States may die because of their unmitigated tobacco use. The proposed tobacco settlement might lead some to conclude that to achieve an "acceptable" level of tobacco use, we need only harden restrictions on tobacco marketing or increase the availability of existing tobacco-dependence treatments. This is untrue. The terms of the settlement also imply that our present understanding of smoking prevention and cessation treatment would enable us to achieve target goals, given sufficient resources. This again is untrue. There are considerable gaps in our understanding of tobacco dependence, especially of growing tobacco dependence in young people. Even in the most optimistic scenario, with tobacco use by the young reduced by 50% in the next five to 10 years, 500 000 young Americans will become chronic smokers each year, with a third to a half of them later dying of tobacco-related disease.

Our national tobacco and nicotine research agenda must be substantially expanded to complement and support any settlement terms. Many basic research questions need to be addressed, but they can not be addressed without funding or oversight. Clearly, some research demands are more pressing than others. Our priorities should include the following.

- The study of the aetiology of nicotine dependence in the young, and adult onset of tobacco use.
- Treatment for tobacco-dependent young people interested in quitting.
- Treatment for special populations, including people with current or past psychiatric disorders and histories of substance abuse, diverse ethnic and cultural populations, and users of tobacco products other than cigarettes.
- Research on the degree to which genetic constitution alters susceptibility to developing nicotine dependence, or modulates the ability to quit, or both.
- Determination of the functional significance of alterations of brain structure and function produced by nicotine exposure.
- Thorough characterisation of the dose-related behavioural effects of nicotine and other tobacco and tobacco smoke constituents which contribute to the dependence process.

Although we now have the elements of a research infrastructure, we lack the framework necessary for building an infrastructure that will last the United States into the next century. Four federal agencies—AHCPR, the Centers for Disease Control and Prevention Office of Smoking and Health (CDC-OSH), the National Institutes of Health (NIH), and the FDA—that already play key roles in coordinating and overseeing such research could be encouraged (and of course, funded) to expand their current work.

Although the Attorneys General are attempting to settle once and for all the damages due to citizens of their states, they have overlooked several costs not borne by the states, as well reparations due to other, equally deserving parties. The CDC estimated total direct medical costs attributable to tobacco use at $50 billion per year; and that the indirect costs of tobacco—among them, productivity lost by employers—amounted to an additional $50 billion per year. Given these numbers, the proposed settlement covers only a tenth to a fifth of the total costs of tobacco to the United States (the second largest tobacco market after China). In addition, the funds the tobacco companies have agreed to allocate to cessation treatments for American smokers provide probably a tenth to a fifth of an appropriately applied cost of reimbursement.

Time and again, we have asked who should pay for smoking cessation treatments. Now the

Johns Hopkins University, Baltimore, Maryland, USA
J E Henningfield

tobacco companies have offered to pay their share. All irony aside, if 20 million American smokers try to quit annually (a number slightly greater than CDC estimates for annual quit attempts made over the last decade), providing even $500 to each of them for cessation treatment would cost tobacco companies $10 billion—considerably more than the $1.5 billion they initially proposed to help smokers end their addiction. Certainly, additional funding is likely to expand treatment access and use. But how can funds be used most efficiently to expand access to and use of cessation treatment? The only viable approach would involve a national cessation programme with appropriate procedures, mechanisms, and modalities. Several questions seem particularly pertinent to this approach, and merit further discussion.

- Who should administer the funds?
- What should be the standards for reimbursing cessation treatment services and medications?
- How can smokers be given incentives to quit and aided in their quit attempts?
- What will be the standards for payment for treatments of special populations when clear guidelines do not exist for their treatment? For example, how should adolescents and addicts of other drugs of abuse be treated?
- How much support should be provided to each smoker for a given treatment and for treatments over the course of that individual's life?

Obviously, treatment approaches must become more flexible and readily available. But as my colleague John Pinney has observed, we need to avoid overstimulating an underdeveloped treatment infrastructure. We also need continued and regular (annual) reviews of both new and existing treatment processes, working along the lines of an AHCPR review process.

Whatever strategy we eventually agree on will demand a degree of vigilance. It is plausible that as barriers slow cigarette marketing to a younger and more impressionable group, there will be increasingly sophisticated efforts to persuade adults to initiate smoking, or to encourage former smokers to resume that activity. To guarantee that new tobacco industry strategies do not produce lasting adverse effects (and that healthcare systems and pharmaceutical companies can respond creatively to waxing and waning tobacco dependence), we need to create novel surveillance systems to supplement existing ones. Among them should be a rapid reporting system that produces results at least quarterly, with reports given on smoking uptake; reports on a wider range of levels of smoking (and not only by daily smokers); and reports on the number of quits attempted in a given population. This type of surveillance would make the universal identification of tobacco users suggested by AHCPR all the more imperative.

The groundwork laid by AHCPR and other agencies and organisations active in tobacco control should not be overlooked in our enthusiasm about long-awaited concessions from the tobacco industry. That said, the proposed tobacco settlement can offer us a measure of hope. It represents an historic attempt by the United States to grapple with a widespread addiction and its attendant costs. Like any intervention, it will probably have its glitches. What matters most is that we undertake it in good faith, following the dictates of science and conscience alike.

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